

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

ARTHUR STEBBINS

V.

C.A. 02-60L

JO ANNE B. BARNHART,
Commissioner of Social Security

REPORT AND RECOMMENDATION

Robert W. Lovegreen, United States Magistrate Judge

This matter is before the Court for judicial review of a final decision of the Commissioner of the Social Security Administration ("Commissioner") denying disability insurance benefits under the Social Security Act ("Act"), 42 U.S.C. § 405(g). Plaintiff filed his complaint on January 30, 2002 seeking to reverse the decision of the Commissioner with or without a remand for rehearing. Plaintiff has filed a motion to reverse the Commissioner's decision with or without a remand for a rehearing. The Commissioner has filed a motion to affirm her decision. This matter has been referred to a magistrate judge for preliminary review, findings and recommended disposition. 28 U.S.C. § 636(b)(1)(B). Based upon my review of the entire record, my independent legal research, and my review of the legal memoranda filed by the parties, I find that there is substantial evidence in this record to support the Commissioner's decision and findings that the plaintiff is not disabled within the meaning of the Act. Consequently, I recommend that the Commissioner's motion to affirm be granted and that the plaintiff's motion to reverse the Commissioner's decision with or without a remand for rehearing be denied.

Background

In June 1998, with a protective filing in May 1998, the plaintiff applied for Supplemental Security Income ("SSI") alleging that he was unable to work due to an aggressive

personality disorder, conduct disorder, and an antisocial reaction. This application was denied initially and on reconsideration by the Social Security Administration ("SSA"). On August 17, 1999, an Administrative Law Judge ("ALJ") held a hearing at which plaintiff, appearing with his counsel, and a vocational expert testified. On March 23, 2000, a supplemental hearing was held at which the plaintiff appeared through counsel, but not personally. At the hearing, medical testimony was obtained from a medical advisor and from a second vocational expert. On April 7, 2000, the ALJ rendered his decision denying benefits as plaintiff was not eligible for SSI.

The plaintiff appealed to the Appeals Council which, in November 2001, denied the plaintiff's request for review. The ALJ's decision then became the final decision of the Commissioner. A timely appeal was then filed with this Court.

Standard of Review

Judicial review of the Commissioner's decision is limited in scope - the decision "will be overturned only if it is not supported by substantial evidence, or if it is based on legal error." Johnson v. Shalala, 60 F.3d 1428, 1432 (9th Cir. 1995); see also Richardson v. Perales, 402 U.S. 389, 401 (1971); Evangelista v. Secretary of Health and Human Services, 826 F.2d 136, 144 (1st Cir. 1987). If substantial evidence can be found in the record which indicates that the claimant is not disabled within the meaning of the Act, then this Court must uphold the decision of the Commissioner. Although less than a preponderance, substantial evidence is "more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Richardson, 402 U.S. at 401 (quoting Consolidated Edison Co. v. NLRB, 305 U.S. 197, 229 (1938)); Mendoza v. Secretary of Health and Human Services, 655 F.2d 10, 13 (1st Cir. 1981).

The plaintiff may be considered disabled within the meaning of the Act only if she is unable to perform any substantial gainful work because of a medical condition which can be expected to last for a continuous period of at least 12 months. 42 U.S.C. §§ 416(i)(1) and 423(d)(1); 20 C.F.R. §§ 404.1505 and 416.905. Her impairment must be so severe as to prevent her from working not only in her usual occupation, but

in any other substantial gainful work considering her age, education, training and work experience. 42 U.S.C. § 423(d)(2)(A); Bowen v. Yuckert, 482 U.S. 137, 146 (1987). Evidence of a physical impairment is not enough to warrant an award of disability insurance benefits; plaintiff must also be precluded from engaging in any substantial gainful activity by reason of such impairment. McDonald v. Secretary of Health and Human Services, 795 F.2d 1118, 1120 (1st Cir. 1986).

If a plaintiff is partially but not totally disabled by impairments, she is not disabled within the meaning of the Act. Rodriguez v. Celebrezze, 349 F.2d 494, 496 (1st Cir. 1965). A plaintiff's complaints cannot provide the basis of entitlement when they are not supported by medical evidence. Avery v. Secretary of Health and Human Services, 797 F.2d 19, 20-21 (1st Cir. 1986).

The Court's review is directed to the record as a whole and not merely to the evidence tending to support a finding. Frustaglia v. Secretary of Health and Human Services, 829 F.2d 192, 195 (1st Cir. 1987). The Court must also determine whether the Commissioner has applied correct legal standards in deciding the claim. Lizotte v. Secretary of Health and Human Services, 654 F.2d 127 (1st Cir. 1980).

Discussion

Factual Evidence

The plaintiff was born on June 20, 1969 making him 30 years old at the time of the hearing. He was single and lives "with other people", but has no permanent home. Tr. at 50. He last had a stable residence about one year before when he rented a room. He stays with friends as long as he can. He has either an 8th grade or 10th grade education and apparently left school when he was 13 or 14. He was in special education. He attempted to go to "tractor trailer school" some time ago but did not finish. The plaintiff is right handed, 5'7" tall and weighs 150 pounds.

A history of employment included working at a Taco's restaurant in Florida where he "mixed beans", New England Container Co. (a chemical company), making sandwiches, and digging holes for a construction company. Tr. at 52-3. Most of the jobs were very short term, from a few days to a few weeks. The chemical job was the longest job lasting almost

one year. Sometimes he was fired and sometimes he quit. He quit because "They just weren't good jobs." Tr. at 53. The last employment was in 1997 when he was making sandwiches which lasted three weeks and he was fired. Tr. at 53. He has a food stamp card, but no cash income. He does odd jobs (he was then cleaning his friend's attic) and has cleaned yards, erected a fence, and painted a hallway. People ask him to do these jobs. He has, on average, been working one week out of each month. Tr. at 55. Sometimes he gets paid, or people will buy him clothes, or buy him "booze." Tr. at 55. He has had no vocational training. He is not able to work because "every time I go to do some work it's always a problem with somebody. You know, they either fire me or I just leave because a bunch of people got a problem, you know." Tr. at 56. "It's either there's always something on my mind. ...it's hard to function sometimes. And these people yell at you. And you can't even think straight." Tr. at 56.

The plaintiff spends his time in his residence so he will not get into trouble. He refers to wherever he is allowed to stay. He recently started treatment with the Providence Center under the care of Dr. Wintrob. He was on medication given to him until he ran out (Celexa and Trilafon). He took this medication for two weeks, but has not been able to go back and obtain more medication. He claimed he owed them money and he was to return in September. He was told that when the medication ran out to see Dr. Wintrob. Tr. at 58. He is to see him in September. He had a prescription which he had filled and there was one refill. He never obtained the refill as he had no money to pay for his visits. He claimed that he would be required to pay \$5.00. He admitted he did not pay anything for the medication he obtained directly from the Providence Center and that he could go to the Center for an additional two weeks supply of medication.

The plaintiff testified he has not been for any psychiatric treatment before as he had no income. He has been jailed in the past (six to nine months) for "checks" (he cashed some bad checks for a friend and the checks were stolen) and larceny (he removed his things from a residence but he was accused of taking someone else's property). Tr. at 61. He was in jail over two years ago and was told then to seek mental health treatment. Tr. at 64. He is able to obtain food with his card and he cooks it at the place he is then staying.

More than 10 years ago, he was taking medications when he was at Worcester State Mental Hospital (2 times for 30 days each) and a place called Prescott (a psychiatric hospital in Massachusetts).

During questioning by his counsel, the plaintiff could not recall his past mental health treatment history. He has no family in Rhode Island as his family lives in Massachusetts, Connecticut, Florida, Maine and Vermont. His mother lives in Massachusetts, but he has no contact with her. A brother lives in Connecticut and he visited with him in late Spring 1999. The medication he took was to assist him in relaxing and to sleep. One medication made him "shake" and he did not believe the medications helped him. He did not experience any change while on the medications. He tends to have mood swings and feels depressed when he "thinks". Tr. at 68. He feels anxious like when he is late or missing something or has forgotten. This is constant. If upset, he hears voices and he does not sleep well. He feels anger and he wants to act out, but "you can't do that." Tr. at 69. He is suspicious and has no close friends. He has been staying at his current residence "a little over a year." Tr. at 69. The girl he is living with is his girlfriend. She has children and he does not like to stay too long as the children get used to him and look at him differently. Tr. at 70.

When the plaintiff applies for jobs, he can tell if the person hiring him likes him or thinks he is stupid. While waiting to be seen again at the Providence Center, he is not being counseled there.

The vocational expert, Louis Testa, then testified that he reviewed the exhibits and was present during the plaintiff's testimony. He reviewed the plaintiff's employment history (Exs. 4E and 7E at Tr. 161-68 and 175-77). The jobs listed therein were unskilled work and ranged from light to medium to heavy work.

The ALJ then suspended the hearing and indicated he would send the plaintiff for a psychological consultative examination and, during the delay, the plaintiff could obtain more information from the Providence Center.

The hearing resumed on March 23, 2000 at which time Dr. Shahzad Rahman testified as well as Robert F. McGinn, a vocational expert. The plaintiff did not appear at this

hearing although his counsel was present. Dr. Rahman was not present at the first hearing but did review all the exhibits in the case. He is board certified in psychiatry. He testified that from May 26, 1998 to the present, the plaintiff was diagnosed with post traumatic stress disorder which was mild based upon childhood physical and sexual abuse. He also has a diagnosis of personality disorder with antisocial and some paranoid traits. He has a history of past substance abuse (marijuana) that is no longer relevant. He has a criminal history of at least 20 arrests for relatively minor matters (lying to the court, stealing, assault). He has symptoms of anxiety, irritability and intrusive recollections of traumatic events. He was raised in foster and group homes where he suffered both physical and sexual abuse, but these symptoms are mild. There is no support in the records for a severe post traumatic stress disorder. His main problem is a predominant demeanor of defiance and aggression. In summary, the plaintiff has a mild post traumatic stress disorder which falls under Rule 12.06, with symptoms of anxiety and multiple traumatic experiences. Also, under Rule 12.08, the plaintiff has a personality disorder, mainly antisocial and some paranoid traits. Tr. at 82-3. The plaintiff has mildly impaired activities of daily living, moderately impaired social restriction due to the aggression, the impairment of concentration is not often, and intelligence and performance and testing for attention and concentration were adequate. There was insufficient evidence of deterioration. The personality disorder is based on aggressiveness. In combination, the mild post traumatic stress disorder and the personality disorder do not change the findings. Tr. at 85-6. In combination, these impairments do not equal or meet the requisite severity needed for the listing for 12.06 or 12.08. Tr. at 86.

Dr. Rahman then reviewed the report of Dr. Parsons' (Ex. 20F, Tr. at 316-28) and his two-page residual functional capacity report (Tr. at 327-28) and concluded that he did not disagree with Dr. Parsons' conclusions. Tr. at 87. Dr. Parsons focused on the personality disorder. Based upon a review of the entire record, Dr. Rahman agreed with Dr. Parsons that the plaintiff had no limitations on his ability to understand, carry out and remember instructions. Dr. Rahman disagreed with Dr. Parsons as to any limitation of response to supervision and felt this was moderate, not moderately severe; disagreed with Dr. Parsons as to limitation of response to co-workers indicating this should be moderate,

not moderately severe; disagreed with Dr. Parsons as to limitations on response to customary work pressures indicating this should be mild, not moderately severe; no limitation on performance of simple tasks, not mild; limitation on complex tasks would be mild to moderate, not moderately severe; limitation on repetitive tasks would be mild, not moderate; and Dr. Rahman did not discuss any limitation on varied tasks.

On examination by the plaintiff's counsel, Dr. Rahman testified that the plaintiff had been defiant as a child and that was not consistent with early post traumatic stress disorder. The records as a whole do not support severe post traumatic stress disorder. Dr. Rahman stated that his review of the entire record did not support any diagnosis of major depressive disorder as considered by Dr. Parsons. The post traumatic stress disorder would be treated with medications, antidepressants, which treat both anxiety and depression. The plaintiff could also use psychotherapy in his dealings with other people.

Robert F. McGinn, a vocational expert, testified that he reviewed the record documents as to the plaintiff's age, education, and work experience. As to the plaintiff's work history, it consists of unskilled work which varied from medium to heavy exertion. Tr. at 96. The longest job he ever held was for about one year. Assuming a person like the plaintiff with the same limitations as testified to by Dr. Rahman (these were given to the witness by the ALJ), the vocational expert testified that the person could perform most unskilled occupations including all the plaintiff's past employment and the only restriction for employment would be based upon his education. Typical jobs at the sedentary level would be bench work (assembler), package sorter, boxer, and cutter. Also, light maintenance work (light duty), general laborer (medium duty), laborer (heavy duty). These categories include all of the plaintiff's past employments. These jobs exist in the "hundreds of thousands" in New England. Tr. at 98.

Mr. McGinn then reviewed the residual functional report of Dr. Parsons (Tr. at 327-28) and testified that if one accepts all of Dr. Parsons' opinions, that person could not function adequately in any work setting.

Medical Evidence

The plaintiff was seen for a consultative examination by Dr. Aminadav Zakai on August 7, 1998. The purpose of the examination was "to evaluate for aggression and decreased concentration." Tr. at 231. The plaintiff complained of "being pre-occupied, getting mad and then doing stupid things." Tr. at 231. Dr. Zakai reviewed the plaintiff's childhood history which demonstrated a difficult upbringing. Also, Dr. Zakai noted that the plaintiff had recently been incarcerated and had a history of alcohol and drug abuse. At the time of the examination, he was drinking some, but not "much these days because when he does he gets into trouble" and he was using marijuana occasionally "as it calms him down and numbs his pain." Tr. at 232-33. He had been incarcerated over 20 times since age 18 and he was 29 years old at the time of the examination. He was under no current psychiatric treatment although he had some treatment while a teenager. He had an irregular employment history performing a variety of jobs including "doing carpets" for 5 years, his longest held job. His most recent employment had been in a deli in a gas station and he quit because the owner "yelled" at him. Tr. at 233.

Dr. Zakai found the plaintiff's mood to be anxious and the plaintiff presented with some depression. His affect was "appropriate and congruent with content of conversation." Tr. at 234. He had mild complaints of depression - mostly a loss of interest and, during the interview, he was anxious, apprehensive and had problems with attention. His thinking was logical, goal oriented, and focused on his present problems. He was not delusional. His attention was moderately impaired, his memory was intact, his intelligence was average with no intellectual loss recently, his fund of information was consistent with his background, and his abstracting ability was normal.

Dr. Zakai diagnosed the plaintiff as having mild post traumatic stress disorder and episodic cannabis abuse. He did not meet the requirements for a diagnosis of antisocial traits. Dr. Zakai commented as follows:

1. [The plaintiff] has the ability to financially manage his benefits.
2. [He] has some impairment in understanding instructions due to his

impaired concentration.

3.[He] has severe impairment to appropriately respond to supervisors and co-workers.

4. [He] has an impairment in working under pressure in a work setting. Tr. at 235.

On August 12, 1998, J. Stephan Clifford, Ph.D., performed a psychiatric review technique and a mental residual Functional Capacity Assessment. Tr. at 217-28. Dr. Clifford noted that the plaintiff had evidence of some anxiety related disorder, personality disorder and substance abuse disorder. In particular, he had anxiety based upon a recurrent and intrusive recollection of traumatic episodes which are a source of marked distress; he had a personality disorder affecting social and occupational functions; and he had a substance addiction which was not material. The plaintiff was noted by Dr. Clifford to have slight limitation in daily living activities; slight limitation in social activities; often had deficiencies in concentration; once or twice had episodes of deterioration in the workplace. Dr. Clifford found that the plaintiff was not significantly limited in many and most activities, but was moderately limited in the ability to carry out detailed instructions, in the ability to maintain attention and concentration for extended periods; the ability to work in coordination with others; and the ability to accept instructions and criticism from supervisors. Tr. at 226-27. Dr. Clifford opined that the plaintiff would be distracted at times and that his focus was poor. He could not perform tasks requiring sustained concentration and he would tend to avoid contact with others. He would not be a team member and would resent authority and not be very cooperative with a supervisor. Tr. at 228.

On November 5, 1998, a similar review was performed by Dr. Claude Curran. Dr. Curran also noted that the plaintiff had evidence of anxiety related disorder, personality disorder, and substance abuse disorder. As to anxiety disorder, Dr. Curran noted that the plaintiff has evidence of recurrent and intrusive recollections of a traumatic experience which were a source of marked stress; personality disorder was evidenced by behavior lability and poor insight; and the substance abuse disorder was determined to be not material. Dr. Curran opined that the plaintiff had slight

limitation in activities of daily living and social functioning; often had deficiencies in concentration; and once or twice had episodes of deterioration in the workplace. As to mental residual functional capacity assessment, Dr. Curran opined that the plaintiff's activities were not significantly limited except for moderate limitations in the ability to carry out detailed instructions; the ability to maintain attention and concentration for extended periods; the ability to work in coordination with others; the ability to accept instructions and respond appropriately to criticism from supervisors; and the ability to get along with co-workers. The ability to complete a normal work day and week ranged from not significantly limited to moderately limited. The remainder of Dr. Curran's report is illegible and will not be considered.

On June 30, 1999, the plaintiff underwent an initial psychiatric evaluation at the Providence Center by Dr. Wintrob. The plaintiff discussed his childhood and indicated he currently was having stress problems due to his past abuse. He was more paranoid in the past two months and felt he was being watched. He was anxious and friends told him to obtain treatment. He stated he had difficulty sleeping. He eats well, but he is mistrusting and irritable. He hears voices telling him he is a loser and he should hurt himself, but he is not violent and has no violent ideations. He was in good physical health and on no medications. He uses alcohol which is not a problem for him and he has a history of cocaine use but not since age 18. He denied use of any other street drugs (he never mentioned using marijuana, yet he did mention this to Dr. Zakai - Tr. at 232-33). He told Dr. Wintrob that he was incarcerated 4 times since age 18 for driving with a suspended license and the most recent incarceration was in 1997 (he told Dr. Zakai that he had been incarcerated over 20 times since age 18 including offenses of lying to the court and assaults - Tr. at 231 - and told Dr. Parsons that he had a "number" of arrests for a variety of crimes - Tr. at 317). Dr. Wintrob described the plaintiff as "disheveled, shabbily dressed and very tense and anxious" with dirty clothes and "his personal hygiene was lacking", Tr. at 308,, yet Dr. Zakai described him as "casually dressed and practices good hygiene." Tr. at 234. As the interview with Dr. Wintrob continued, the plaintiff was less distracted and he began to pay attention and focus on the questions. Rapport was adequate and maintained after a few minutes and he was cooperative. His behavior was less bizarre and he was less

tense and anxious as the interview proceeded. He had low self-esteem and was depressed with great pessimism for the future. Dr. Wintrob diagnosed the plaintiff with "Major Depression; recurrent; severe with Psychotic Symptoms Post Traumatic Stress Disorder; very severe; since childhood ? Schizotypal Disorder of Schizophrenia; possibly Paranoid Type." Dr. Wintrob prescribed Celexa and Trilafon and provided the plaintiff with a two weeks supply. He was to return in one month. He failed to keep an appointment for July 15, 1999 with Dr. Wintrob. He was seen by a licensed social worker before and after Dr. Wintrob's evaluation (only once after the evaluation). Tr. at 315.

On July 21, 1999, Dr. Wintrob prepared a Supplemental Questionnaire as to Residual Functional Capacity. Tr. at 311-12. Therein, Dr. Wintrob opined that the plaintiff had severe impairments in all areas except moderately severe impairment in deterioration of personal habits, moderately severe impairment in understanding, carrying out and remembering instructions and moderately severe impairment in performance of repetitive tasks. He had moderate impairment in performing simple tasks.

On October 14, 1999, the plaintiff was referred for a diagnostic psychological assessment to John P. Parsons, Ph.D. Dr. Parsons was requested to comment on the plaintiff's mental status and assess the current levels of social and emotional functioning. The plaintiff stated that "Everybody says I should apply for Social Security because of all my troubles. I've had bad decision-making, and I don't deal with stuff. I can't concentrate on my work when I have to do work." Tr. at 316. At the examination, the plaintiff was casually dressed and his hygiene was "somewhat neglected." Tr. at 316. His gross and fine motor skills were normal; his work tempo was average; his attention and concentration spans were appropriate; and he was not distracted. His recall was vague; speech was monotonous but fluent and intelligible; no difficulty with hearing; he had a limited sense of humor; he was irritable; there was fair rapport; and he was cooperative. He described his difficult childhood and indicated he left school at age 18 while in the 10th grade (he told Dr. Wintrob he quit school at grade 8). There were no physical problems. He had difficulty sleeping. He uses alcohol and had a history of alcohol abuse. He was last intoxicated in June 1999. He has a history of cocaine and marijuana abuse, but stated he had not used drugs for a "number of years." Tr. at 319. (He

told Dr. Zakai in August 1998 that he still used marijuana occasionally to calm him down. Tr. at 232-33.) He does his own cooking, shopping and cleaning and handles his finances. Dr. Parsons reviewed the records of Drs. Zakai and Wintrob.

Dr. Parsons concluded that the plaintiff was able to handle his daily activities. The plaintiff denied any particular hobbies or special interests (he told Dr. Zakai that he enjoys reading and outdoor activities such as camping and fishing which he has done - Tr. at 233). He would have difficulty in relationships with others, especially authority figures. He is able to follow and understand directions without any impairment and his short term memory is average. He is able to complete routine household tasks without significant impairment.

Dr. Parsons concluded that the plaintiff meets the criteria for post traumatic stress disorder. He had average general intelligence. Dr. Parsons advised that the plaintiff should return to the Providence Center for outpatient psychotherapy and antidepressant medication. There is no indication in this record that the plaintiff did this.

Dr. Parsons also completed a Supplemental Questionnaire as to Residual Functional Capacity and opined that the plaintiff had moderately severe impairments in all areas except mild impairment as to personal habits; no impairment as to the ability to understand, carry out and remember instructions; mild impairment of the ability to perform simple tasks; and moderate impairment of the ability to perform repetitive tasks and varied tasks. Tr. at 327-28.

Administrative Decision

In determining whether a claimant is disabled under the Social Security Act, the Commissioner employs a five step sequential analysis. 20 C.F.R. §§ 404.1520 and 416.920; Bowen v. Yuckert, 482 U.S. 137, 140-42 (1987); Goodermote v. Secretary of Health and Human Services, 690 F.2d 5, 6-7 (1st Cir. 1982). First, the adjudicator determines whether the claimant is performing substantial gainful employment ("SGA"). If she is, she is not disabled and the analysis is at an end. If she is not, step two requires a determination of whether a severe impairment exists. If it does not, claimant is not disabled. If it does, step three requires a determination of whether claimant's impairment meets or equals a listed

impairment in 20 C.F.R. Part 404, Subpart P, App. 1. If a listed impairment is found, claimant is disabled. If not, step four requires a determination of whether claimant can perform her past relevant work. If she can, claimant is not disabled, and if she cannot, step five requires a determination of whether she can perform any other work in the national economy considering her age, education, and past work experience. If she can perform other work, she is not disabled and if she cannot, she is disabled.

In addition, the ALJ must give consideration to any allegations of pain in light of the criteria set forth in 20 CFR 404.1529 and consider the treating sources' opinions in light of 20 CFR 404.1527.

As to the first step, the ALJ found that the plaintiff has not engaged in substantial gainful employment since the alleged onset of disability. As to the second and third steps, the ALJ found that the plaintiff has an impairment or a combination of impairments considered severe, but which do not meet or equal a listing. The ALJ also found that the plaintiff's testimony and other statements concerning his impairments lacked credibility based upon a comparison of these alleged impairments and the record of this matter. The ALJ then found that the plaintiff has the following residual functional capacity: "work at all exertional levels limited by a moderate reduction in ability to respond appropriately to supervision or coworkers; a mild reduction in ability to respond to expectations of attendance, perseverance, and pace; a mild to moderate reduction in ability to perform complex tasks; and a mild reduction in ability to perform repetitive or varied tasks." Tr. at 33. As to step four, the ALJ found that the plaintiff could perform his past relevant work as a dishwasher, bagger, meat packer, laborer, and piece counter as these activities did not require work activities precluded by his post traumatic stress disorder and/or his personality disorder. In step five, the ALJ found that the plaintiff had the capacity to perform many types of employment which are available in significant numbers in the national and regional economies.

As a result, the ALJ found that the plaintiff was not disabled within the meaning of the Act. The plaintiff has raised several objections to the decision which will be discussed.

Steps Four and Five: The ALJ Erroneously Evaluated the Opinions of the Three Specialist Examiners

The plaintiff argues the the opinions of the three examining specialists, Drs. Zakai, Wintrob and Parsons, do not support the ALJ's finding that the plaintiff has a moderate reduction in his ability to respond appropriately to supervision or coworkers. Dr. Zakai did state in his report that the plaintiff had a severe impairment to respond appropriately to supervisors and coworkers. Tr. at 235. Dr. Parsons stated that the plaintiff had a moderately severe limitation on his ability to respond appropriately to supervision and to coworkers. Tr. at 327. Dr. Wintrob stated that the plaintiff had a severe limitation on his ability to respond appropriately to supervision and to coworkers. Tr. at 311.

However, what the plaintiff fails to state is that each of these doctors (M.D. or Ph.D.) examined the plaintiff only once and based their decisions on that one visit. There was additional testimony from a medical expert on this issue. Dr. Rahman, a Board certified psychiatrist, reviewed the entire record in this matter including the reports of the three other doctors and disagreed with these findings. He testified that the record supported a finding of moderate limitations as to the ability to respond appropriately to supervision and to coworkers. Tr. at 38 (discussing Dr. Parsons' residual functional capacity findings at 327). The plaintiff had previously testified that the reasons he quit some of his jobs were because "They just weren't good jobs I guess." Tr. at 53. This defies the conclusion that he could not always withstand the stress of supervision or that of coworkers and that his limitation here was severe or moderately severe.

While it is accurate to state the the ALJ generally gives more weight to the opinion of an examining physician than a non-examining physician, 20 CFR § 416.927(d)(1), that is not mandatory in all cases. The plaintiff cites to Rose v. Shalala, 34 F.3d 13, 18 (1st Cir. 1994) for support as to the argument that a non-examining physician's opinion should not be considered substantial evidence overcoming the consistent reports of examining physicians. However, Rose stands for the proposition that the "ALJ is not free to substitute his own judgment for uncontroverted medical opinion." Id. at 18. The ALJ did not do that here, rather, he relied upon the sworn testimony of the medical expert who had reviewed the entire

record. Rose also states that the weight given to the conclusions of a non-testifying and non-examining physician "will vary with the circumstances, including the nature of the illness and the information provided the expert." Id. (quoting Berrios Lopez v. Secretary of HHS, 951 F.2d 427, 431 (1st Cir. 1991)). Rose does not stand for the proposition that an examining physician (or 3) always overrules a non-testifying and non-examining physician. It is the circumstances that govern. Here, the 3 physicians relied upon by the plaintiff's statements and were not totally consistent (moderately severe to severe). In all three reports, the basis for the opinion was information supplied by the plaintiff, not anything based upon a medical finding, and the ALJ found the plaintiff to be not credible. This Report and Recommendation has included examples of the inconsistencies in the plaintiff's testimony and what he told the physicians. Here, the medical opinion relied upon by the ALJ was from a testifying non-examining physician, one who reviewed the entire record and is Board certified in psychiatry. Under the circumstances, any holding in Rose does not prohibit the ALJ from relying on the testifying medical expert. Otherwise, why have a medical expert testify? I find that neither Rose nor § 416.927 prohibits an ALJ from relying upon the testimony of a testifying non-examining medical expert and that it was appropriate for the ALJ to do so here.

Step Four: Stebbins Did Not Have Past Relevant Work

The plaintiff argues that he has no past relevant work as such work was performed "off-and-on or for brief periods of time." The plaintiff cites to 20 CFR § 416.965(a). Section 416.965(a) also states "We consider that your work experience applies when it was done within the last 15 years, lasted long enough for you to learn to do it, and was substantial gainful activity." This section contains no definition of "off-and-on" or for "brief periods of time." However, this record reflects a compilation of the plaintiff's work history prepared by the plaintiff. Tr. at 161-68 and 175-77. Unfortunately, the plaintiff only listed the year(s) when the employment ceased rather than the exact dates of employment so it is impossible to know the length of the employment. Certainly, this record indicates the the times of these employments varied widely. For example, the plaintiff told Dr. Parsons that his longest employment was for one year without naming the type of employment. Tr. at 317-18. Apparently, he did not discuss his past employment with Dr.

Wintrob as there is no discussion of this topic in Dr. Wintrob's report. The plaintiff informed Dr. Zakai that his past employment included that of "doing carpets" which employment lasted 5 years and was his longest employment. Tr. at 233. Interestingly, this employment is not included in the work history prepared and filed by the plaintiff.

It is difficult to determine any basis for the plaintiff's statement that he "worked for only short periods of time", Plf.'s Mem. at 15, except for a one year stint at New England Container Co. Tr. at 52. It is not the burden of the ALJ or the Commissioner to prove past relevant work. Here, the plaintiff did nothing to show he did not have past relevant work until he received an adverse decision and then, for the first time, he disputed that his past employment was past relevant work. Had this issue been raised properly before the ALJ, it could have been considered and perhaps more information could have been obtained. But the plaintiff cannot wait until the decision is rendered and then raise the issue initially. Here, the ALJ was concerned about the medical evidence and did have the plaintiff examined by Dr. Parsons. There was plenty of opportunity for the plaintiff to dispute this issue and/or obtain more information for the ALJ's consideration. He failed to do so. It is the claimant's burden to prove he is entitled to benefits. Boyes v. Secretary of HHS, 46 F.3d 510, 512 (6th Cir. 1994).

I find that there is substantial evidence in this record to support the Commissioner's final decision. I find no basis for concluding that the ALJ failed to evaluate the entire record properly. He exhaustively outlined plaintiff's testimony. He was equally complete in summarizing the substantial medical evidence. He correctly concluded that the medical evidence and the plaintiff's allegations did not support a finding of disability. The ALJ is not bound by plaintiff's self-serving allegations, Bianchi v. Secretary of Health and Human Services, 764 F.2d 44, 45 (1st Cir. 1985), and may reject them where, as here, the testimony is unsupported by the whole medical evidence and where the medical conditions would not reasonably be expected to produce the limitations alleged. 20 CFR § 404.1529; Frustaglia, 829 F.2d at 194-195; Avery, 797 F.2d at 21. The ALJ thoroughly considered the evidence of record in reaching his credibility finding, and that finding is entitled to deference. DaRosa v.

Secretary of Health and Human Services, 803 F.2d 24, 26 (1st Cir. 1986). I find no error on the part of the ALJ in applying these standards.

In short, I find no error in the ALJ's analysis of this record or in his conclusion. I find no basis for reversing the decision of the Commissioner. To reverse the decision of the Commissioner would require this Court to substitute its own opinion for that of the ALJ. The Court cannot do this. Lizotte, 654 F.2d at 128.

For the reasons stated, I recommend that the district court grant the Commissioner's motion to affirm and deny the plaintiff's motion to reverse with or without a remand for rehearing.

Any objection to this Report and Recommendation must be specific and must be filed with the Clerk of Court within ten (10) days of its receipt. Rule 32, Local Rules of Court; Fed.R.Civ.P. 72(b). Failure to file specific objections in a timely manner constitutes a waiver of the right to review by the district court and the right to appeal the district court's decision. United States v. Valencia-Copete, 792 F.2d 4 (1st Cir. 1986); Park Motor Mart, Inc. v. Ford Motor Co., 616 F.2d 603 (1st Cir. 1980).

Robert W. Lovegreen
United States Magistrate Judge
January 17, 2003